

# 9.3 Sexual history and examination 1600

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**ESSENTIALS** Sexually transmitted infections are common, especially in young people, and it is important that doctors recognize both the need to obtain a sexual history and when to perform genital examination. Sexually transmitted infections can present with generalized or extragenital symptoms, the significance of which might be missed. This chapter gives advice on how to take a sexual history and perform genital examination in both sexes. It also summarizes the common symptoms and syndromes associated with sexually transmitted infections and their causative pathogens, cross-referring to other chapters in the textbook.

**Introduction** Sexually transmitted infections (STIs) are a common cause of morbidity, especially in young people. Although many STIs are asymptomatic, important symptoms may be missed because patients are not questioned directly about genital symptoms (Table 9.3.1). If a sexual history is not taken, the risk of an STI might not be appreciated. In general medical practice, it is important that doctors are aware that STIs can present with extragenital symptoms (Table 9.3.2). Examples include secondary syphilis, primary HIV infection, disseminated gonococcal infection, and herpes simplex meningitis. Failure to consider a sexually acquired infection in the differential diagnosis might delay diagnosis and treatment.

**Sexual history** A sexual history is essential to establish the patient's risk of an STI, to elicit symptoms that might guide diagnostic tests, and to facilitate treatment of sexual partners who might be at risk (partner notification). If an STI is diagnosed, the discussion is extended to provide relevant information about the condition and to educate on reducing future risk. The clinician must ask questions that are extremely personal. Initially this can be mutually embarrassing for the doctor and patient. The clinician should endeavour to see the patient alone as they might be reluctant to reveal personal information, especially about previous sexual activity, if their current partner is in the room. It can be difficult for a young person to talk about sexual activity if a parent is present. Sexual history taking is facilitated by

- being explicit about confidentiality
- asking permission, explaining what to expect, and why you are asking the questions
- asking only what is relevant and necessary
- starting with the less intrusive questions, such as symptoms, before asking the ones that are more personal
- using appropriate language and tact
- not making assumptions about sexual orientation or practices

**Asking questions** Use open questions such as:

- 'Are you sexually active?'
- 'Are you in a relationship?'
- 'Have you

changed partners recently?’ • ‘Do you have sex with men, women, or both?’ • ‘When was the last time you had any kind of sex?’ The key features of a sexual history are: • symptoms • details of sexual partner(s): gender, timing of last sexual activity, use of condoms or contraception, whether partner is contactable or not, whether partner reported any symptoms • concurrent illness • previous STI • current medication • in women, assessment of pregnancy risk However, many STIs may present with extragenital symptoms or signs (Table 9.3.2). Examination In symptomatic patients, examination is necessary because a visual diagnosis might be possible, examination might suggest the need

9.3 Sexual history and examination Gary Brook, Jackie Sherrard, and Graz A. Luzzi

9.3 Sexual history and examination 1601 for further tests, and might also identify complications that need longer or altered treatment regimens (e.g. pelvic examination might suggest pelvic infection requiring a specific treatment regimen). In asymptomatic patients, genital examination is also recommended because patients are often surprisingly unaware of the presence of infection. Although symptoms may be denied, important abnormalities might be found on examination. The increased availability of nucleic acid tests allows noninvasive sampling for many STIs; however, genital examination should always be considered. Examination involves full inspection of the genito-anal area in both sexes, including palpation of the inguinal nodes and examination of the pubic area. Good lighting is essential. In patients with syphilis, late HIV disease, sexually acquired reactive arthritis (SARA), and disseminated gonococcal infection, a full examination is necessary. Some non-STIs can present with genital signs (e.g. lichen sclerosus, lichen planus, psoriasis, eczema, Crohn’s disease); in these cases, a full examination can be helpful in making the diagnosis. In men, examination of the genital area includes palpation of the scrotal contents to detect epididymal or testicular swelling or tenderness. This is best carried out while the patient is standing up. Epididymal cysts are relatively common, especially with increasing age. Acute epididymitis causes tender swelling of the epididymis, usually unilaterally, sometimes with involvement of the testis (epididymo-orchitis) causing generalized testicular swelling and hydrocele. In uncircumcized men, the foreskin should be fully retracted and the subpreputial area inspected for rashes, ulcer, and lumps. The urethral meatus should be everted slightly and inspected for discharge, and lumps such as genital warts. In men who have sex with men (MSM) who report practising anal sex, the anal/perianal region should be examined; the rectum inspected by proctoscopy if there are rectal symptoms; and, if they report orogenital sex, the oropharyngeal mucosae should be inspected for ulcers and other abnormalities. In women, examination includes careful inspection of the vulva, which is best performed in the lithotomy position. The vagina and cervix should be inspected by speculum examination and a bimanual examination performed to check for cervical or adnexal tenderness and pelvic masses.

Table 9.3.1 Common presentations of STIs

Symptoms Common causes (see Section 8 and Chapters 9.4 and 9.5)

In women

Change in vaginal discharge Candida, TV, BV, less commonly GC, CT

Anogenital sores/ulcers Herpes simplex, trauma, syphilis

Anogenital lumps Genital warts, molluscum contagiosum, normal anatomical variants

Pelvic pain/dyspareunia and/or irregular menses Pelvic inflammatory disease: CT, GC, MG

In men

Urethritis: urethral irritation/discomfort and/or discharge Chlamydia, gonorrhoea, MG

nonspecific urethritis Anogenital sores/ulcers Herpes simplex, trauma, syphilis

Anogenital lumps Genital warts, molluscum contagiosum, normal anatomical variants

Scrotal pain/swelling Chlamydia, gonorrhoea

Additionally in men who have sex with men (MSM)

Rectal pain/discharge/tenesmus GC, CT, LGV, HSV, Syphilis

BV, bacterial vaginosis; CT, chlamydia; GC, gonorrhoea; HSV, herpes simplex virus; LGV, lymphogranuloma venereum; MG, Mycoplasma

genitalium; TV, Trichomonas vaginalis. Table 9.3.2 Some extragenital symptoms or signs of STIs

System/category	Syndrome/site	Causes (see Sections 7 and 25, and Chapter 19.8)
Eyes	Uveitis, conjunctivitis, optic neuritis, retinitis	Syphilis/HIV/GC/CT/SARA
Joints	Tenosynovitis/septic arthritis especially of small- and medium-sized joints	Septic arthritis Syphilis/GC/SARA (CT associated)/HIV
GC	Skin	SARA, GC, HIV, syphilis, scabies, molluscum contagiosum, pubic lice
Cardiac	Syphilis, GC, HIV	Malignancy
Carcinomas:	cervix, vulva, penis, anus, lymphoma, Kaposi's sarcoma	HPV, HIV
Gastrointestinal system	Hepatitis, perihepatitis	diarrhoea
Hepatitis B and C, CT	HIV, LGV	CT, chlamydia; GC, gonorrhoea; LGV, lymphogranuloma venereum; SARA, sexually acquired reactive arthritis.

Section 9 Sexually transmitted diseases 1602 Role of chaperones

In the United Kingdom, the General Medical Council has produced guidance on intimate examinations, which includes:

- the routine offer of a chaperone
- giving the patient privacy to undress and dress
- explaining to the patient why examination is necessary and what it will involve
- obtaining the patient's permission before the examination and discontinuing it if the patient asks you to

Before performing an intimate examination (examination of the genitalia, rectum, or breast), a chaperone should always be offered and the offer recorded in the notes along with a note indicating who the chaperone was. If the offer is declined, this should be recorded, and it might be necessary to reschedule the examination if the doctor does not feel comfortable about proceeding without a chaperone. During general examination, especially when male doctors examine the heart and lungs of female patients, misunderstandings can arise about perceived inappropriate touching of the breasts. The manner in which the examination is conducted is therefore clearly very important, with appropriate explanation and professionalism. The general examination is often conducted in the absence of a chaperone, but there are circumstances in which a chaperone should be sought, including when this is requested by the patient, or if the doctor feels that it is appropriate. A chaperone is present as a safeguard for all parties (patient and practitioner) and is a witness to continuing consent of the procedure. However, a chaperone is not a guarantee of protection for either the patient or the practitioner, and for most patients, explanation, consent, privacy, and a respectful and professional attitude take precedence over the need for a chaperone. When issues arise about individual clinical practice, good record-keeping is very helpful.

FURTHER READING Clinical Effectiveness Group: British Association for Sexual Health and HIV (2014). 2013 UK National Guideline for Consultations Requiring Sexual History Taking. <https://www.bashh.org/documents/Sexual%20History%20Guidelines%202013%20final.pdf>. Int J STD & AIDS, 25, 391-404.

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